Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
ORTHOPEDIC PHYSICAL THERAPY

MFDR Tracking Number
M4-14-1792-01

MFDR Date Received
February 20, 2014

Respondent Name
LIBERTY INSURANCE CORP

Carrier's Austin Representative
Box Number 01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Letter received on 10/23/13 acknowledging that services were authorized. Copies of claim forms, medical notes and EOBs indicating a denial of payment for no authorization."

Amount in Dispute: $560.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Attached are copies of the preauthorization denial letter and the latest EOBS for each date of service in dispute. Preauthorization was requested and denied. As this is not a Certified Network claim, it would not be appropriate to bill through MedRisk for these services."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 23, 2013 – August 22, 2013	97713-GP x 7	$560.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all-applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the Preauthorization, Concurrent Utilization Review, and Voluntary Certification of Health Care.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - X388 – Pre-authorization was requested but denied for this service per DWC Rule 134.600.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed.

Issues

1. Did the requestor obtain preauthorization for the disputed services?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.600 states in pertinent part, "(p) Non-emergency health care requiring preauthorization includes: (5) physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels: (A) Level I code range for Physical Medicine and Rehabilitation, but limited to: (i) Modalities, both supervised and constant attendance."

   The requestor seeks resolution of non-payment for CPT Code 97113, defined by the AMA CPT Code Book as "Therapeutic procedure, 1 or more areas, each 15 minutes; aquatic therapy with therapeutic exercises." Preauthorization for CPT Code 97113 was required per 28 Texas Administrative Code §134.600.

   Review of the insurance carrier's letter dated October 2, 2013 states, "Per your request, I'm providing written confirmation that we authorized 12 PT visits for [injured employee's] left hip and left leg injury..." However, the notification letter contained no dates of service and no authorization number, therefore the Division is unable to determine if the disputed dates of service were part of the 12 PT visits authorized by Liberty Mutual. The requestor submitted no further documentation to support how this letter related to the disputed services.

   Review of the insurance carrier's preauthorization letter dated July 19, 2013 states "Therefore, the additional eighteen sessions are not medical necessary..." and identified the dates of service as 07/17/2013 to 08/28/2013, as a result, the Division finds that the insurance carrier submitted sufficient documentation to support that preauthorization was requested, however not authorized by the carrier. As a result, the requestor is not entitled to reimbursement for disputed CPT Code 97113-GP rendered on July 23, 2013 through August 22, 2013.
2. Review of the submitted documentation finds that preauthorization was required and not obtained, as a result reimbursement cannot be recommended for the disputed charges.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 8, 2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.